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.100 THIRD PARTY PAYORS GENERALLY

Third party payors are companies or agencies who pay for the services provided to subscribers. This includes commercial insurance companies such as Trigon BCBS, Aetna, Cigna, etc. and any HMO's.

Billing third party payors for services rendered is a courtesy provided to clients, however, the client is ultimately responsible for payment.

.200 MEDICAID

Medicaid was established in 1969 as a part of the Social Security Act under Title XIX and is administered by the Department of Health and Human Services.

In Virginia, the Department of Medical Assistance Services (DMAS) under the direction of the Secretary of Health and Human Resources has the responsibility to administer Medicaid services under the State plan. The DMAS has contracted with the Department of Social Services (DSS) for the determination of financial eligibility for medical assistance and the provision of related social services.

Medicaid, an assistance program, is for certain needy and low income people; i.e., the aged, (65 or older), the blind, the disabled, members of families with dependent children and some other children. Medicaid is a federal-state partnership. Money from federal, state, and local taxes pays medical bills for eligible people. Medicaid can pay what Medicare does not pay for people who are eligible for both programs.

For further information, refer to the following manuals:

- Medicaid Mental Health Clinic Manual
- Medicaid Community Mental Health Rehabilitation Services
- Medicaid Mental Retardation Community Services
- Medicaid Rehabilitation Manual
- Medicaid Nursing Home Manual (ICFMR)
- Medicaid Medallion

These manuals can be accessed at the Department of Medical Assistance Services' website:
<http://www.cns.state.va.us/dmas/>

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.300 MEDICARE

Medicare (officially known as Title XVIII of the Social Security Act-Health Insurance for the aged and disabled) is a federal health program for individuals 65 years of age or older and certain disabled individuals. It is run by the Centers for Medicare & Medicaid of the Health Care Financing Administration (HCFA) of the U.S. Department of Health and Human Services.

Medicare is, in fact, two separate and distinct programs. The two programs differ with respect to type of benefits, method of financing, nature of participation by beneficiaries, and the legal basis for their operation. These two programs are generally designated by sections of the Title XVIII from which they originate - Part A and Part B.

The fiscal intermediary for the Medicare program is TrailBlazer. Further information may be obtained at the following website: <http://trailblazerhealth.com/>

.400 ANTHEM BLUE CROSS BLUE SHIELD

Trigon Blue Cross Blue Shield issues a provider number for each category of provider to the community services boards. Those categories are: Physician, Certified Nurse Specialist, Speech Therapist, Physical Therapist, Licensed Clinical Social Worker, and Licensed Professional Counselor.

A provider agreement must be completed by the community services board in order to become a participating provider.

Coverage may vary according to the subscriber's contract. Call the Provider Inquiry Unit at the number below to check benefits.

Richmond	804/342-0010
Other areas	800/533-1120

For contracts that have psychiatric benefits managed, care must be authorized before services are rendered. Further information may be obtained at the following website: **www.anthem.com**

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.500 TRICARE (Formerly CHAMPUS)

The TRICARE program was formerly known as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). TRICARE is the name of the health care program for the DoD (Department of Defense). TRICARE is a network of military and civilian hospitals, clinics, and medical professionals. It offers a wide range of health care benefits and guarantees timely access to care. The health care delivery network is contracted by the DoD to manage the TRICARE Mid-Atlantic and TRICARE Heartland regions. TRICARE, as its name implies, gives beneficiaries three options for care: TRICARE Prime, TRICARE Extra and TRICARE Standard. TRICARE Standard is the TRICARE basic benefit program and remains the same as Standard CHAMPUS.

All individuals entitled to military health care who are under the age of 65 are eligible for participation in TRICARE. Certain Medicare eligibles over age 65 may also be entitled to TRICARE benefits. This includes active duty military personnel and family members, and retired service members and their family members and survivors. All eligible for military health benefits.

Persons not eligible for TRICARE include: Medicare eligible beneficiaries (except active duty family members and others as defined by TRICARE), CHAMPVA beneficiaries, and Active Duty Personnel or eligible beneficiaries currently enrolled with United States Treatment Facility. Further information may be obtained at the following website: <http://www.tricare.osd.mil/>

.510 CHAMP/VA (Civilian Health and Medical Program of the Veterans Administration)

CHAMP/VA is a health benefit program for the families of veterans with 100% service-connected disability and the surviving spouse or children of a veteran who dies from a service-connected disability. Once eligibility has been established, benefits are cost-shared the same way that TRICARE covers families of retirees.

.520 DEERS (Defense Enrollment Eligibility Reporting System)

In order to have TRICARE claims processed and to receive non-emergency care in service hospitals, TRICARE eligible military personnel and their families must be enrolled in DEERS. DEERS is a worldwide database of military families, retirees and others covered by TRICARE. Enrollment in DEERS is required of both active and retired military sponsors and all family members.

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.600 OTHER THIRD PARTY PAYORS AND HEALTH MAINTENANCE ORGANIZATIONS (HMO)

All other third party payors and / or health maintenance organizations (HMOs) should be handled as follows:

1. Have the client sign an Authorization for Release of Medical Information and an Assignment of Benefits form.
2. Verify coverage during the client's initial intake making sure that the clinician providing the service is a reimbursable provider.
3. It is important to determine if services must be pre-authorized. Obtain pre-authorization / certification if required. Failure to do so could cause denial of payment. Pre-authorization may also be necessary when a primary care physician refers a client for services.
4. Many third party payors and / or health maintenance organizations (HMOs) require claim forms be filed with the carrier within 30 days after the date of service.
5. It is important the CSB becomes familiar and thoroughly understands the requirements outlined in the provider participation agreement, as well as, any provider manuals that are issued by the third party payor and / or health maintenance organizations (HMOs). Being knowledgeable of the third party payor and / or HMO specific billing requirements will avoid unnecessary claim denials.